TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Poly America LP

MFDR Tracking Number
M4-16-3723-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
August 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Medicare guidelines, CGS DME MAC Jurisdiction C, 3rd quarter 2014, E0217 RR is supposed to be reimbursed at $60.44 per unit x 125%. Even though the EOB states fee schedule. We do understand that this is only allowed to be billed once monthly. We are only billing this once monthly but for 7 units."

Amount in Dispute: $476.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "E0217/RR is priced correct to $76.38 per Texas DME pricing to CMS DMEPOS 2016."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2016	E0217, RR	$476.62	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Non Certification determination based on UR outcome

- 1 – Rental reimbursements have not reached the threshold value or the rental payments have been reimbursed less than maximum number of occurrences.
- 2 – Formatted EOR message unavailable. Event message – No reduction available
- 3 – The charge for this procedure exceeds the fee schedule allowance
- 39 – Services denied at the time authorization/re-certification was requested
- BL – This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payments
- W3 – Request for reconsideration

Issues

1. Is the requestor's position supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement for HCPCS Code E0217-RR rendered March 29, 2016 in the amount of $476.62. The insurance carrier issued a payment in the amount of $76.38 and reduced the remaining charges with reduction codes "1-Rental reimbursements have not reached the threshold value or the rental payments have been reimbursed less than maximum number of occurrences" and "3-The charge for this procedure exceeds the fee schedule allowance."

   HCPCS Code E0217 is defined as "Water circulating heat pad with pump." The requestor appended modifier RR to identify that the DME service in dispute is a rental and not a purchase.

   The requestor in their position summary, states in pertinent part, "We do understand that this is only allowed to be billed once monthly. We are only billing this once monthly but for 7 units." Review of the submitted documentation titled, "Delivery Ticket" indicates "Qty" 1 for rental of E0217. This document was signed by the claimant on March 29, 2016.

   The division finds that the submitted documentation supports the reimbursement of one (1) unit for the rental of E0217-RR. The requestor is therefore entitled to reimbursement for the rental of E0217-RR pursuant to the applicable rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   28 Texas Labor Code §134.203(d) states in pertinent parts,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   Review of the DMEPOS fee schedule finds the following;

   - The Medicare, 2016 2nd Quarter, Texas Fee Schedule amount found at www.dmepdac.com/dmecsapp/do/feesearch, for submitted code is as follows:
     - E0217 –RR - $61.10 (1) unit. Review of submitted delivery ticket supports one unit not seven as submitted on medical claim. $61.10 x 125% = $76.38
     - Total allowable = $76.38

3. The maximum allowable for the services in dispute is $76.38. The carrier previously paid $76.38. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 21, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.